

CHAPTER SIX

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Social Construction and Narrative Family Practice

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ostmodern family therapies are most associated with narrative, collaborative language systems, reflecting team therapy, and other models that ascribe to social constructionism. Postmodernism refers to a movement in our culture away from the belief in, and search for, fundamental truths. Some have described this movement as a result of the evolving complexity of our view of the world: The "postmodern Mind is one which . . . has come to question whether [reality] is ordered in a way in which man's reason can lay bare" (Smith, 1989, p. 7). Postmodernism has been described as "a linguistic theory that proposes that the social world cannot be treated as an objective system" (Pardeck, Murphy, & Jung, 1994, p. 343). Postmodernism does not reject outright reality, science, or technology. Rather, postmodernism is interested in exploring the ways in which language, power, social factors, and history shape our views about reality, truth, and knowledge (Hollinger, 1994, p. 177). Social work has recently begun to define the importance of this intellectual movement on theory and practice (Franklin, 1995; Pardeck et al., 1994; Saleebey, 1994).

This chapter describes the new and evolving family therapy models that have been influenced by postmodernism. The theory and assumptions of postmodernism are discussed, along with the major therapeutic techniques used. The consistency of postmodern practice perspectives with social work practice are further highlighted. Beginning research studies that hold promise for establishing an empirical basis for postmodern family therapies are also discussed. Some of the promising features of postmodern practice in today's contexts of behavioral health

are highlighted. Finally, a case study that illustrates the postmodern practice is presented.

History

Postmodernism has recently influenced family practice models and represents a newer social-cultural orientation to family therapy (Laird, 1995). Family therapies such as those using the social construction theory and narrative approaches have been associated with postmodern practice perspectives. The historic roots of these approaches can be found in the systemic models; however, postmodern family practice models also depart from traditional systemic thinking and practice. The family practice models associated with postmodernism evolved out of systemic perspectives and sometimes in reaction to those models. Most of the progenitors of the models were originally trained as systemic family therapists. Feminist and multicultural critiques of traditional family therapy models are influential in setting the stage for the postmodern perspectives. Some practitioners also became disenchanted with constructivist, strategic models and wanted to explore new ways of conceptualizing and working with families (Hoffman, 1990). Other factors in the development of postmodern family practice include an increasing tendency to see the family as an open system influenced by many other social systems, an increasing awareness of the importance of language in therapy, an interest in postmodern social science theories, and a new interest in including social action and social and cultural critique as part of the therapy process. Therapists such as Michael White, David Epston, and Lynn Hoffman were especially influential in advocating both a sociopolitical view of therapy and the need for social action to change dominant narratives that are present because of the oppressive influences of the larger society and culture (Hoffman, 1992; White & Epston, 1990).

Theoretical Basis for the Practice Model

Kurt Lewin (1951) once observed, "There is nothing so practical as a good theory" (p. 169). A theory orients us to the pragmatics of therapy: how we define problems, how we understand the origins of problems, who we talk with about problems, how we set goals, and how we determine our successes. For the newcomer to postmodern therapies, a theoretical understanding is often facilitated through an exemplification of the practice of postmodern therapies. As David Hunt (1987), rephrasing Lewin, has put it, "There is nothing so theoretical as good practice." We illustrate the practice below, but first we discuss some of the assumptions undergirding postmodernism.

Major Assumptions

Postmodernism assumes that there is no singular, universal reality but many possible understandings of behaviors, interactions, or events and that language serves

as the primary vehicle for the transmission of meanings and understandings. These ideas have profound implications for therapists' behavior. Postmodernism can be illustrated through considering the art of the last century. Historically for artists, the fundamental problem was how to accurately represent the three-dimensional world on a flat canvas. Artists mastered the laws of perspective, color, and composition in an attempt to provide the viewer with a near-perfect representation of reality. As we moved into the 20th century, the artist's goal became a presentation on the canvas that would convey the artist's impressions, or interpretations, of the subject, rather than a re-presentation. The artist's goal was to convey the meanings a subject evoked in the artist, how the artist felt about the subject, and perhaps an attempt to evoke in the reader a similar feeling for the subject. Artists became less absorbed in the problem of representing a reality and more fascinated with evoking realities and experiences in the viewer. Similarly, in anthropology, one finds a movement away from the idea that an ethnography accurately portrayed the life and culture of some civilization in an "objective" manner. Instead, ethnographies have come to be understood as resulting from interactions between the anthropologist, the culture under study, and the reader of the document (Clifford & Marcus, 1986). This trend in anthropology is mirrored in popular culture, as exemplified by Paul Simon's *Graceland* album, the increased diversity of ethnic foods in grocery stores and restaurants, and the multiculturalism that pervades society.

Postmodern thinkers are disenchanted with unadaptable norms. The appreciation of context has given rise to notions such as "situational ethics," which depend on circumstances, individuals, and local expectations. This is different from the "engraved in stone" Ten Commandments understanding of ethics. In the criminal justice system, the question is often not "Did he do it?" but "Why did he do it?" If the contextual reason is satisfying, the guilt is mitigated. Although we frequently attribute behavior to the makeup of individual psyches, there is an increasing appreciation for the impact of context on behavior.

Social Constructionists

One important group of postmodernists are the social constructionists (Berger & Luckman, 1966; Gergen, 1985; McNamee & Gergen, 1992). In an attempt to define how we make sense of the world if we abandon the quest for foundational and knowable truths, the social constructionists have turned to our social natures. For them, the world we perceive and the meanings that we create about that world are the result of social interactions—that is, talking with other people and living in a cultural context that transmits meanings to us.

Social constructionism emphasizes a crisscrossing of ideas in our conversations with one another (Anderson & Goolishian, 1988). This does not mean that we exchange ideas like trading cards. Rather, there is a recognition that what we say to you is interpreted in a unique and particular way. The understandings created are shaped by, and will shape, other ideas. We then make a unique interpretation of others' understanding. Rather than exchanging trading cards, we are passing a ball of modeling clay back and forth, each of us squeezing it and shaping it to our own liking before passing it back. The clay changes somewhat with

each exchange. The constructionist position is that even though we habitually act on a particular meaning as if it were the only meaning, as if it were the only truth about a problem, it is only one of several plausible meanings or interpretations of the same events or behaviors.

This concept implies that meanings are transitory, changing from moment to moment in the conversation, like the ball of clay. Meanings are constantly "under construction" from this point of view. Ultimate, foundational "Truths" are viewed with a great deal of skepticism by social constructionists.

Therapeutic Methods

Therapists, regardless of theoretical orientation, set the stage for therapeutic interaction by determining the procedures that will be followed. Procedural details include setting, composition of the client system, goals of therapy, role of the therapist, and criteria for termination. These procedural details are somewhat independent from the process of therapy. We briefly discuss the procedures that are characteristic of therapists working within a postmodern perspective and turn to processes and techniques in the next section. It is important to remember that postmodern family therapists are theoretically diverse, and guidelines for working from this perspective are still emerging.

Setting

Many advocates of postmodern approaches (Andersen, 1991; Anderson & Goolishian, 1988; Hoffman, 1990) work in settings that utilize therapy teams. Although most postmodern family therapists practice alone, the influence of working in teams remains. It has been previously argued that the use of teams is a preferred method for training in postmodern therapy (Biever & Gardner, 1995; Bobele, Gardner, & Biever, 1995). Teams can take a variety of forms in postmodern practice, but reflecting teams are most closely associated with this form of therapy. Reflecting teams were developed in Norway by Tom Andersen and his colleagues (Andersen, 1987, 1991). The reflecting team is a departure from the Milan-style team structure (Slevini-Palazzoli, Boscolo, Cecchin, & Prata, 1980) in that clients listen to the intersession team discussion rather than waiting for feedback/messages to be delivered by therapists. (See Chapter 3 for a discussion of the Milan approach.) Reflecting teams allow clients direct access to the team's ideas rather than funneling the team's ideas through the therapist.

The applications of reflecting teams have been expanded by several authors. For example, Furman and Ahola (1992) describe using a joint discussion format in which they extend the sharing of therapists' ideas with clients to all conversations therapists have regarding clients, including consultations, pre-session conversations, and post-session conversations. Anderson and her colleagues at the Houston Galveston Institute have dispensed with the use of one-way mirrors; the team remains in the room with clients and therapists throughout the therapy session. Therapists who work in co-therapy teams may incorporate the reflecting process by talking with each other. For instance, Madigan (1993) describes the use of "lis-

tening therapists." Listening therapists are situated in the room along with the therapist(s) conducting a session (performative therapists) and the clients. During the session, in the clients' presence, questions the listening therapists ask about the questions the performative therapists asked in the therapy session are periodically discussed.

Therapists who work alone may also incorporate a reflecting position into their work. For instance, brief breaks may be taken as "thinking time" for the therapists. Therapists may leave the room or simply ask for a few minutes to reflect on the session up to that point. Clients may be invited to do the same. Therapists and clients then share their reflections. Wangberg (1991) suggests that therapists should differentiate reflecting comments from other therapeutic exchanges by looking at the floor or window while reflecting. Reflecting is talking *about* clients, not *to* them. Reflecting offers the opportunity for a different type of conversation. The reflective stance is discussed further in a later section.

Composition of Client System

Therapists who are influenced by social constructionism think in terms of social and cultural contexts. Thus, they often work with families or larger social systems. Anderson and Goolishian (1988) proposed that the therapeutic system should comprise all who are in conversation about the problem situation or person. Hoffman (in Simon, 1993) prefers the formulation that problems create systems rather than thinking that systems create problems. As such, the client system may comprise family members, extended family, or others involved with them, such as teachers or social service workers. Many postmodern therapists work with individuals and couples, smaller groups of the larger social system, while remaining mindful of the larger context.

Role of the Therapist

Traditionally, therapists were viewed as experts who conceptualize cases and develop treatment plans from their theoretical orientation. In contrast, the role of postmodern family therapists is to facilitate therapeutic conversations, in which the therapist actively attempts to learn about clients' perspectives and understandings. Sluzki (1992) describes this role as facilitating or promoting changes in specific stories or the relationship between stories. Therapists are respectful of clients' understandings and positions regarding their presenting problems. All explanations and descriptions are viewed as viable and are taken seriously. Therapists' understandings of clients' stories are introduced as possibilities or tentative hypotheses rather than as prescriptions for "better" stories or ways of understanding. These ideas are presented with the goal of generating conversation, not providing answers.

Goals of Therapy

Postmodern family therapists generally start therapy by eliciting clients' views of their situation and how it is problematic for them. Clients' self-stated problems are the issues attended to in therapy. Therapeutic goals are not determined by theoretical

ideas as to what is "healthy" functioning, nor are the self-stated problems viewed as merely symptomatic of underlying conflicts that can be determined only by therapists. Normative assessment and diagnostic procedures are typically not used to determine the focus of treatment. Diagnostic labels are viewed as just one of many possible descriptions of problems. The danger of using such labels is that such descriptions frequently lead to understandings that are not helpful to clients. The goal of therapy is to expand understandings and possibilities. There is not a particular emphasis on behaviors, feelings, or thoughts. Clients may emphasize one or more of these; however, therapists are more interested in the meanings that are created by the stories surrounding behaviors, feelings, and thoughts.

Termination

Termination of therapy is seen as evolving gradually from therapeutic conversations. Anderson and Goolishian (1988) discuss termination of therapy as the "dissolving" of the problem-saturated story. Therapy ends because behavior, interactions, or the understandings of problem behavior have changed. Clients are assumed to be the better judges of when therapy is no longer needed.

Therapeutic Techniques

As postmodern family therapies evolved from philosophical theories, therapists began rethinking therapeutic techniques. Therapists who incorporate postmodernism into their practices use a variety of techniques. However, the focus is on changing meanings and understanding rather than on changing behaviors. Indeed, some proponents (e.g., Anderson & Goolishian, 1988) argue against deliberate interventions. In contrast, Epston (1993) argues that social constructionist perspectives may become an endangered species of potential practice if the theory is not translated into practices. This idea, espoused by Epston, is especially applicable to the new practice contexts of managed behavioral health care in which we must be able to define our methods and evaluate their effectiveness.

An obstacle in describing the techniques of postmodern family therapies is that these approaches to therapy were developed by a number of different individuals and groups, diverse in geography and culture: Harry Goolishian and Harlene Anderson in Texas, Michael White in Australia, David Epston in New Zealand, Tom Andersen in Norway, and Lynn Hoffman in Massachusetts. Postmodern family therapies have also been described by a number of different names. For example, Michael White and David Epston's model has been called narrative therapy, and Goolishian and Anderson's model, the collaborative language systems approach. Lynn Hoffman's ideas have been referred to as social constructionism. Tom Andersen is best known for the reflecting team therapy. These therapists, however, share a common philosophy. As stated by de Shazer (1993), for every theoretical idea there are at least 40 clinical practices or techniques that can express it. Indeed, practices of postmodern therapy value multiple perspectives and the belief that there are many "right" ways to do anything. With this in mind, we illustrate some of the common emphases of postmodern therapies: therapeutic stance, conversations, meanings, and narratives in therapy.

How to Conduct a Session

THERAPEUTIC STANCE

The postmodern therapeutic stance is characterized by collaboration, not-knowing, curiosity, and reflecting.

Collaborating. For many, the primary difference between traditional modern and postmodern therapies is the position, or stance, that therapists take in relationships with clients. Therapy from the postmodern perspective is a collaborative effort between clients and therapists. Therapists make active efforts to reduce unhelpful effects of hierarchy rather than adopting a one-up/one-down relationship in which therapists' ideas dominate. There is a sense of being "in this" *with* the client instead of searching for deficits, traumas, or dysfunctions.

Not-knowing. O'Hanlon (1993) described the therapeutic relationship as one in which

clients and therapists are both considered experts. Clients are experts on their own experience, including their pain, suffering, and concerns. They also have expertise about their memories, goals, and responses. Therapists are expert at creating a conversational and interactional climate for change and results in therapy. Clients and therapists are partners in the change/therapy process and collaborate on deciding the focus for therapy, the goal to be sought, and when therapy should come to an end. (p. 12)

Anderson and Goolishian (1988, 1992) have called this the "not-knowing position." Therapists who adopt this stance assume that understandings and explanations in therapy should not be bounded by the therapist's previous experience or theoretical knowledge. Therapists ask questions to increase their understanding of the client's world, not to gather data to formulate a conventional diagnosis. Therapists' ideas are viewed as being no more useful or valid than are the client's ideas. Therapists' expertise lies in the conduct of the therapeutic conversation, which generates new ideas and meanings with clients. Therapists may introduce new ideas, explanations, or descriptions, but clients are ultimate judges about the usefulness of the ideas.

Curiosity. An emphasis on maintaining curiosity is also characteristic of postmodern approaches to therapy (e.g., Cecchin, 1987). Anderson (1995) suggests that therapists display curiosity by learning a little about one thing and then moving on to other areas to avoid giving the impression that they are interested in only one narrow part of clients' experiences. Anderson and Goolishian (1992) suggest that therapists should not "understand" too quickly. When therapists "understand" clients, the possibilities for expanding and creating meanings become limited. The position of curiosity is a different stance from modernist approaches that put therapists in an investigatory stance fixed on discoverable "facts" or ideas.

Reflecting. The term *reflecting* was introduced by Andersen (1987, 1991) in his descriptions of reflecting teams. The idea of reflecting has been expanded and is now used both to describe a process (reflecting conversations) and a stance (reflecting position) therapists may use whether they work in teams, co-therapy, or alone.

Andersen (1992) described the reflecting process as inner and outer conversations that allow therapists and clients to shift back and forth between talking and listening. He further explained, "These two different positions in relation to the same issues seem to provide two different perspectives, and these two perspectives of the same will most probably create new perspectives" (p. 62). Hoffman (1992) uses the word *reflexive* to describe her similar approach to therapy:

To me the word implies that there is an equity in regard to participation even though the parties may have different positions or different traits . . . [reflecting conversations] . . . indicate a preference for a mutually influenced process between consultant and inquirer as opposed to one that is hierarchical and unidirectional. (p. 17)

Thus, Hoffman focuses on how the reflecting process influences the nature of the relationships between clients and therapists. Griffith and Griffith (1994) describe the reflecting position as

a listening position. In its most fundamental aspect, it is a place in a conversation where one can listen to others talk without feeling compelled to respond to what is heard, or listen freely to one's inner talk without feeling compelled to relegate it to total secrecy or total exposure. (p. 160)

MANAGING CONVERSATIONS

The postmodern therapist's expertise is in the management of a special type of conversation, the therapeutic conversation. Therapeutic approaches based on postmodern perspectives depict the nature of therapeutic conversations more often than specific techniques. As social interactions are conducted largely through language, language is viewed as the primary vehicle for the transmission and construction of meanings and understandings. Anderson and Goolishian (1988) explain:

Therapy is a linguistic activity in which being in conversation about a problem is a process of developing new meanings and understandings. The goal of therapy is to participate in a conversation that continually loosens and opens up, rather than constricts and closes down. Through therapeutic conversation, fixed meanings and behaviors (the sense people make of things and their actions) are given room, broadened, shifted, and changed. There is no other required outcome. (p. 381)

Such conversations open space for change, are tentative, and take a both/and stance.

Opening Space for Change. The goal of the conversation is the creation of an opportunity for change by introducing new possibilities. Therapists ask questions that extend and expand the conversation while avoiding questions that constrict conversations. Constricting questions are those to which the answer is already known, those that are intended to lead clients to conclusions the therapists believe are correct, and those that elicit answers that support the therapists' theories about the cause of and/or solutions to the clients' problems. Such questions tend to restrict opportunities for the development of new understandings.

Harlene Anderson (1995) suggests that *shared inquiry* is the essence of the therapeutic conversation. Shared inquiry occurs when the therapist's interest and curiosity about the client's view results in a "mutually puzzling process in which

therapist and client become engaged in conversation with each other in coexploring the familiar in a manner that leads to codevelopment of the new" (p. 36). Shared inquiry leads to a dialogue in which both people change.

Freedman and Combs (1993) describe questions designed to elicit meaningful experiences for the client. They identify three categories of questions that may be useful in this process: opening space questions, story development questions, and meaning questions. Opening space questions are aimed at generating alternative experiences and knowledge. Therapists may inquire about exceptions to the problem description, explore others' views of the problem situation, or inquire about changes (or potential changes) in the problem over time or in different circumstances. Story development questions and meaning questions are discussed later.

Tentativeness. The presentation of ideas in a nonauthoritarian manner is frequently advocated by postmodern family therapists. Offering ideas in a tentative manner may invite clients to offer their own thoughts and ideas more freely. Harlene Anderson (1995) believes that tentativeness may be conveyed by the use of unfinished sentences or hanging words and phrases such as *wondering*, *kind of*, or *maybe*. Tom Andersen (1991), in discussing guidelines for reflecting teams, suggests that the team members present "a smorgasbord of ideas" versus correct "interpretations," and offering ideas not as "rigid explanations but as tentative thoughts" (p. 133). Stating ideas tentatively may be a natural consequence of adopting postmodern ideas.

Both/And Stance. Andersen (1987) suggests that therapists adopt a both/and stance in place of an either/or stance. This flows from the postmodern idea of multiple, socially constructed realities and the valuing of diversity. The both/and stance extracts therapists from the position of determining who is "right" in family disagreements. The focus is on understanding how each position came about without choosing which is the best. Often, exploring intents or underlying meanings provides a way out of either/or standoffs. When therapists take this stance, often even logically inconsistent ideas can coexist.

EXPANDING MEANINGS

A postmodern perspective emphasizes that meanings and understandings are fluid and always changing. Psychological theories are viewed as nothing more than agreed-on understandings that have proven useful in one or more contexts (Howard, 1991). As no account or interpretation of reality can be considered more valid than any other, the focus shifts to deciding how and when a theory may be useful rather than trying to prove particular theoretical ideas. Therapists who work from this perspective often begin therapy by exploring the client's understanding of the problems or concerns instead of exploring the client's fit with the therapist's theories about the nature of psychological problems, diagnostic categories, and change. As noted by O'Hanlon (1993), therapy is a balance between acknowledgment of clients' realities and creation of new possibilities. Therapists should always keep the arrival of meaning "on the way" (Anderson & Goolishian, 1992).

Furman and Ahola (1988) describe interviewing techniques that explore clients' causal explanations or their impressions of others' causal explanations. They note that clients often infer therapists' explanations from the kinds of questions that are asked and that agreement leads to cooperation whereas disagreement leads to lack of cooperation. Thus, it is important for therapists to understand both clients' own causal explanations and clients' impressions of the therapists' explanations. Furman and Ahola encourage therapists to display curiosity and avoid expressing agreement or disagreement with the clients' explanations.

One way to explore causal explanations of clients is to ask direct, explanation-seeking questions. It may be easiest to start by asking for clients' impressions of others' explanations, like "What does your son's teacher think caused this behavior?" These types of questions are similar to the "relationship questions" used in solution-focused therapy as described in Chapter 5. If clients hesitate, therapists may need to reformulate the question or ask clients to use their imaginations: "But if you could know the reason, what would it be?" At times, it may be useful for therapists to speculate about alternative explanations to demonstrate that they are not seeking the one "correct" explanation.

Furman and Ahola discuss several advantages of exploring client explanations. Asking for client explanations indicates respect for the opinions of clients and shows that their opinions are valuable. Also, by seeking out the explanations of each person in the system, therapists acknowledge the importance of each person's opinion. This helps therapists avoid unintentional coalitions with some members of the system. Exploring alternate causes of problem behaviors may also have the effect of loosening firmly held explanations and allowing for the exploration of other explanations and new possibilities. Finally, working *with* clients' explanations may lead to efficient and effective change.

Freedman and Combs's (1993) meaning questions may be used to expand or create understandings and to assure that the story that is the focus of therapy is an experience that matters to clients. Such questions invite clients to look at the implications of the content of conversations in therapy. Examples of meaning questions include "What does finding out that your spouse appreciates this about you let you know about your relationship?" or "Now that you see your family this way, what do you know about your relationships to one another that you didn't know before?" (p. 301). Tom Andersen (1991), in discussing reflecting teams, suggests that observing therapists keep two questions in mind as a way of expanding meanings: "How else can this situation/behavior/pattern be described?" and "How else can it be explained?" These questions are useful for therapists who work alone, as well. By asking such questions, therapists will remain open to, and help generate, new possibilities.

Harlene Anderson (1986) suggests that therapeutic impasses occur in conversations when each of the participants believes that his or her description or explanation of a situation is correct and tries to convince the other(s) to adopt this position. This competition of ideas may cause the participants to become increasingly rigid in adhering to their own beliefs. Thus, the conversation becomes "stuck," with little opportunity for the development of new ideas or behaviors.

Such impasses may occur among the various members of the client system or between therapists and one or more members of the client system. This view of impasse reminds therapists to ask themselves "Who is trying to convince whom of what?" when therapy seems "stuck." For her, a therapeutic impasse occurs when meanings cease to be expanded and become constricted.

USING STORIES AND NARRATIVES

A focus on stories or narratives is common in postmodern therapies. Lynn Hoffman (1990) has described problems as stories people tell themselves. The terms *narratives* and *stories* are often used interchangeably. Following the lead of Saleebey (1994), we use *stories* as the descriptions and explanations given to events, interactions, and experiences told in the context of smaller systems, such as families, work groups, neighbors of individuals, families, or other social groups. *Narratives* are used to describe stories based on the norms or expectations of larger cultural groups. Narratives are cultural tales that set parameters for what stories are possible. Therapists work primarily with stories of individuals, couples, and families, though at times it may be helpful to place these stories in a larger context, such as single-parenting narratives or family violence narratives. Generally, postmodern family therapists believe that the presenting problem is one "story" that could be told, and that the story may change with each subsequent telling. Changing the story changes the meanings attached to events, behaviors, and interactions.

Stories and narratives are used in several ways by modern and postmodern family therapists. One way the use of stories varies is the source of the story. Generally, in modern approaches, therapists either generate the story (therapist-created metaphors), transform client stories into what therapists believe are more adaptive stories (e.g., Gardner, 1971), or fit the life stories of clients into a preconceived theoretical structure (e.g., psychodynamic approaches). That is, "the client's narrative is either destroyed or incorporated—but in any case replaced—by the professional account" (Roberts, 1994, p. 169). Postmodern family therapists tend to focus on client-generated stories. However, the amount of direction provided by therapists varies. We view the range of differences among postmodern therapists as falling along a continuum—from correcting or editing stories to facilitating client-generated changes.

Theorists who prescribe more direction from therapists include Michael White (White, 1993; White & Epston, 1990) and those who have built on his work (e.g., Parry & Doan, 1994). White focuses on the ways clients' stories are constrained by dominant social and cultural narratives, such as oppressive stories that develop out of abusive situations. Re-storying often involves the externalization of problems. Problems are externalized (described as some external thing that is affecting the person rather than a part of the person) to separate the person from the problem and/or restraints that maintain the dominant story. Questions are then asked to assess the influence the problems have over clients versus the influence of clients on the problems. Literary devices, including letters, documents, and certificates, become a few of the means by which clients rewrite their relationship with problems.

Another narrative approach focuses on changing the structure of stories independent of content (Sluzki, 1992). Sluzki defines a therapeutic conversation as one in which "a transformation has taken place in the family's set of dominant stories so as to include new experiences, meanings, and (inter)actions, with the effect of loosening of the thematic grip of the set of stories on symptomatic-problematic behaviors" (p. 219). Therapists may facilitate the transformation of client stories by attending to the following dimensions: time, space, causality, interactions, values, and the telling of the story. Sluzki describes a continuum for each of these dimensions along which stories may shift. Where clients' stories fall on the continuum is not important; the job of therapists is simply to help clients shift the position.

Roberts (1994) also focuses on narrative structure in her description of differing styles of storytelling. In *intertwined* stories, events that occurred at one point in time are used to interpret other events in the clients' lives. Such stories may collapse time so that the past is lived in the present. On the other end of the continuum are *distinct/separated* stories. When stories are disconnected, there is no access to meaning-making across contexts. No connections are made, even when there are similar dilemmas. In *minimal/interrupted* stories, there is little access to historical time and few details from which meanings are derived. *Silenced/secret* stories are hidden; meanings are unclear and confusing and may contain hidden alliances or coalitions. Time may appear to be frozen in *rigid* stories, with interpretations remaining unchanged across tellings by different persons. When stories are *evolving*, there is a recognition that stories may change over time.

Roberts suggests that story type influences which therapeutic approaches may be useful. For instance, therapists may explore differences between intertwined stories or the similarities between disconnected stories. With minimal stories, therapists can ask questions to fill in the missing pieces. Likewise, with silenced/secret stories, therapists can work with clients to decide whether, when, where, and how stories may be shared. Therapists may expand rigid stories by inquiring about different perspectives or different possible endings. Evolving stories may be identified by asking questions regarding change over time and how changes affected persons and relationships.

Griffith and Griffith (1994) describe narrative factors that may prevent people from escaping dilemmas: (1) lack of vocabulary or linguistic distinctions needed to articulate life experience in narrative form, (2) life stories that prevent the sharing of some personal experiences, (3) stories that lead to consequences that are too terrible, and (4) social practices (political, cultural, religious, etc.) that prescribe dilemmas but prevent discussion. Griffith and Griffith call these stories *binding*. They suggest helping medical clients expand their bound stories to include the meanings and effects on family members, alternative ways of viewing illness when they are feeling blamed, and the history of encounters with medical personnel.

The least direction is advocated by therapists who focus on developing stories rather than on providing frameworks for changing stories. Therapy is seen as an opportunity for clients to explore a variety of stories while discouraging commitment to any one truth (Gergen & Kaye, 1992). The collaborative languaging approach developed by Anderson and Goolishian (1988, 1992) provides one model for this way of thinking. Asking questions from a not-knowing position leads to

"the unfolding of these 'yet-unsaid' possibilities, these 'yet-unsaid' narratives" (p. 34). Further, "the creation of new narrative or knowledge is not standardized; it is realized in the process of conversation and relationship" (Anderson & Swim, 1993, p. 150). Freedman and Combs (1993) are also nondirective in their use of questions to develop the stories brought in by clients. Story development questions are aimed at connecting newly developed possibilities to contexts, people, and the past and future. They suggest that the standard journalist's questions of "Who? What? When? Why? and How?" can be used to expand narratives.

Applications to Specific Problem Areas

ABUSE AND VIOLENCE

Several writers have presented the use of the narrative metaphor with victims of sexual or physical violence. The focus is generally on the types of stories that developed around the abusive experiences. It is noted that some people, but not necessarily all, who have experienced violence and abuse may develop stories about themselves that are limiting. Adams-Westcott, Dafforn, and Sterne (1993) find that problems often develop when people perform oppressive stories about themselves and their relationships. Further, Durrant, and Kowalski (1990) note that persons victimized by sexual assault may develop limiting or constraining stories about themselves as helpless and incompetent.

In working with the perpetrators of family violence, White (1989) suggests that a patriarchal ideology be presented to couples as an alternative explanation of domestic violence. Patriarchal narratives are such

that women are the property of men and, following from this, the idea that men have the right to do with their property whatever they wish; and the notion of hierarchy as the natural order, of man's unquestionable entitlement to assume the superior position in this natural order, accompanied by a very great emphasis on control of those less entitled beings (women) by "power-over" tactics. (p. 102)

The stories that are told around the behaviors of both partners can then be examined in the context of a cultural narrative. Clients can be asked to explore the differences that would result from challenging the patriarchal narrative.

Jenkins (1990) provides another framework for therapy with men who are abusive to family members. He suggests that the focus should be on factors that restrain men from acting responsibly rather than on factors that "cause" persons to act violently. Examples of factors that may restrain responsible behavior include gender expectations, exaggerated sense of entitlements, preoccupation with sense of personal adequacy and competence, and misguided attempts to control abuse. Explanations of abusive behavior are evaluated according to the extent to which they help perpetrators take responsibility for abusive behaviors, point to plausible and accessible solutions ending the abuse and related problems, and are sensitive to all levels of context (e.g., individual, family, cultural). Jenkins's approach invites men to address their violence, argue for a nonviolent relationship, examine misguided efforts to contribute to the relationship, and externalize restraints such as male ownership, oppressive feelings, patterns of reliance, and avoidance of

responsibility. Jenkins then asks clients to consider their readiness for change and facilitates the planning of new actions. New actions to be considered include promoting safety and nonviolence, promoting self-responsibility, demonstrating respect and ownership, and demonstrating responsibility for past abusive behavior. Clients are encouraged to attribute their own meanings to changes.

CULTURAL ISSUES

González, Biever, and Gardner (1994) have described the similarities between the social constructionist and multicultural perspectives in therapy. Both perspectives recognize the importance of social contexts in understanding meanings, behaviors, and relationships. Each perspective challenges therapists to work at understanding clients' worlds without making a priori assumptions. With respectful curiosity, therapists work within the cultural and social frameworks to expand understandings and possibilities.

Waldegrave (1990) argues that therapy that does not address cultural meanings may distance clients from their closest relationships. For him, "Good therapy engages authentically with people's woven pattern of meaning, and then in appropriate ways weaves new threads of resolution and hope that blend with, but nevertheless change, the problem-centered design" (p. 19). He urges therapists to search for "liberating traditions" within each culture. The idea is that some undesirable behavior may reside within larger cultural traditions that have value and that can be used as a positive therapeutic force. For example, when working with clients from cultures with rigid gender roles, therapists may focus on the value and skills involved in the traditional roles. Thus, both/and situations can be created that explore the possibilities of a person's belonging to the culture while having a sense of equity. Working within a postmodern perspective allows therapists to respect cultural variations and to nurture those differences without trying to fit clients into molds shaped by the dominant culture.